Congregate Client Application Form

Site Location:

First Name	Last Name	Gender	DOB

Home Address:				
City	State	Zip Code	Township	County

Phone Number	Number in Household	Income
		Is your income Above $15,000 Yes / No

Ethnicity Hispanic	Race (Mark all that apply)		
Yes / No	African American Asian	Hawaiian / Pacific Islander Indian / Alaskan	White Other

Nutrition Risk Assessment
(Self-Declared Statements)

	Yes	No
I have an illness or condition that thas made me change the kind or amount of food I eat.		
I take three or more different prescribed or over the counter drugs a day.		
I have tooth or mouth problems that make it hard for me to eat.		
Without wanting to, I have lost or gained 10 pounds in the last six months.		
I am not always physically able to shop, cook, and/or feed myself.		
I eat less than two meals a day.		
I don't always have enough money to buy the food I need.		
I eat few fruits, vegetables, or milk products.		
I eat alone most of the time.		
I have three or more drinks of beer, liquor or wine almost every day.		
Do you eat alone most of the time?		

Doctors Name:	
Doctors Number:	

Emergency Contact:	
Emergency Number:	
Contact Relationship:	

Signature of Participant: ______________________ Date: ____________